AMBULATORY RISK MANAGEMENT QUARTERLY REPORT QUARTER 4 CY23

Occurrence Category CY23 (BHP, BHPO, CDTC,BHW, BHC)	Q4	%
PATIENT CARE	28	29%
SECURITY	25	26%
SAFETY	11	11%
FALL	10	10%
MEDICATION	9	9%
HIPAA/PHI	8	8%
ADR	2	2%
PPID	2	2%
LAB	1	1%
DELAY	1	2%
Grand Total	97	100%

TOTAL OCCURRENCES CY23 Q4:

Minimum increase in reports when compared to previous quarter (96).
BHP reported 64% of all occurrences, BHPO 14%, BHCO 11%, BHCD 6% and Weston 5%.
Twenty three reports were related to employees, most BHCO.
Eight visitor events.

PATIENT CARE CY23	Q4
TRANSFER TO HIGHER LEVEL OF CARE	13
DISRUPTIVE BEHAVIOR	6
PATIENT NONCOMPLIANCE	2
ACTIVITY INJURY	2
EQUIPMENT ISSUE	2
AMA	1
RAPID RESPONSE	1
PHYSICIAN MANAGEMENT	1
Total	28

PATIENT CARE:

BHP reported 18 of the 28 occurrences.
Appropriate steps followed for 3 Baker Act events.
Care appropriate with physician management occurrence.
Equipment issue related to CT scanner down, vendor contacted, tests rescheduled.

SECURITY CY23	Q4
PROPERTY DAMAGED/MISSING	7
AGGRESSIVE BEHAVIOR	6
CRIMINAL EVENT	4
ACCESS CONTROL/LOCKDOWN	3
SECURITY PRESENCE REQUESTED	2
ASSAULT	1
THREAT OF VIOLENCE	1
Total	24

SECURITY:

Eleven reports from BHP, 8 from BHCO and 5 BHPO.
Vehicle accidents reported to claims and insurance if involving BH vehicles.
Assault observed on camera outside facility prior to opening reported to police.
Converter stollen from parked BH vehicle at Spectrum. BH van missing from ISC parking. Claims and insurance notified.
Three laptops missing from employee desks at1700 Spectrum. Safety and security looking into installing additional cameras. Devices were encrypted.

MEDICATION VARIANCES CY23	Q4
WRONG PATIENT	4
UNORDERED DRUG	1
WRONG DOSE	1
WRONG CONCENTRATION	1
WRONG DRUG	1
LABELING ERROR	1
Total	9

MEDICATION VARIANCES:

All events from BHP.
Number of occurrences decreased (Q3-19) when compared to previous quarter after pharmacy action plan related to the verification/data entry process.
Wrong drug provided by Walgreens.
Vaccine administered to wrong patient. One near miss wrong patient.
Wrong vaccine dose administered.

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FALL CY23	Q4
WHILE AMBULATING	2
SLIP	2
FROM CHAIR	2
SIDEWALK	2
FOUND ON FLOOR	1
FROM INFANT CARRIER	1
Total	10

FALL:

Seven reported by BHP, 2 by CDTC and 1 by BHPO.
Four patient falls, three visitors and three employees.
No environmental hazards identified.
One minor injury and one transfer to ED for laceration repair.
First notice to claims related to child fall during CDTC contracted OT session.

SAFETY CY23	Q4
SAFETY HAZARD	7
FIRE/SMOKE/DRILL	2
SHARPS EXPOSURE	1
BIOHARZARDOUS EXPOSURE	1
Total	11

SAFETY:
Occurrences from BHP, CDTC, BHPO and Corporate.
Post exposure protocol followed for needle stick with employee re-education on PPE use.
Delay to reach 911 when calling from ALW corrected.
Facilities worked on BHPO exam room with mold smell after heavy rain.
Some related to homelessness conditions outside BPA.

HIPAA/PHI CY23	Q4
UNAUTHORIZED DISCLOSURE	4
PAPER	2
ELECTRONIC IMPERMISSIBLE DISCLOSURE	1
VERBAL	1
Total	8

HIPAA/PHI:

Reports from BHP, CDTC, Corporate and Weston.
Compliance further investigates HIPAA/PHI events and ensures employee corrective action process and retraining.
Two breaches identified.

LAB CY23	Q4
OBTAINED INCORRECTLY	1
Total	1

LAB:

Reported by BHP. Wrong tube used for culture swab was recollected.

PPID CY23	Q4
WRONG PATIENT	2
Total	2

PPID:

Both from BHP.
Test results scanned into wrong EMR.
US performed and documented in wrong EMR. Action planning on proper

DELAY CY23	Q4
COMMUNICATION FAILURE	1
Total	1

DELAY:

Reported by BHP.

ADR CY23	Q4
ALLERGY	1
MISCELLANEOUS	1
Total	2

ADR:

Pain to vaccine injection site reported by BHP and contrast reaction not requiring treatment by Weston.

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REGIONAL RISK MANAGEMENT SECTION : (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES , SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

BHMC RM contacted Ambulatory RM on 11/27/23 regarding fetal demise of patient who had prenatal at CEB.
Retroplacental clot was observed intraoperatively, consistent with a placental abruption.
Although US tech (recently hired) noted the abnormal condition (low amniotic fluid) and documented it on his preliminary report, he failed to contact the maternal fetal medicine physician on schedule responsible for reading the test prior to patient leaving prenatal area.
Director of operations and nurse manager reinforced process with US tech and ensured he has all he needs to perform his duties.
Maternal fetal medicine physician took more than 24 hours to read the US. Discussed with administrator for women and children services.

TDAP given to wrong patient.
MA stated that the providers handle patient stickers with VOs while she is on hallway and this is not a safe process. She used to work at high risk prenatal and they had a system of documentation on forms for any orders outside established prenatal protocol that were at the desk which facilitated team work.
MA said that she saw two orders from the APRN for Depo and assumed one was for Tdap.
MA alleged she was not trained to work at prenatal I.
Office supervisor will implement process/forms from high risk prenatal at prenatal I.
Nurse manager will perform PIP with MA.
Nurse manager will review policy CHS-007-057 with director of women's services and share risk manager concerns. Policy CHS-007-057 Prenatal Laboratory Standing Orders was last revised in 2018. A power plan is a computerized grouping of best practices orders approved by the medical director. The RN/LPN/MA may order the appropriate labs based on gestational age.
MA verbalized understanding that she cannot assume any orders, and these need to be verified with provider and she needs a written order in chart prior to administering any meds.
HR was contacted and recommended CA level 1.
Director of women's services spoke with APRN regarding orders placed.

Trend identified related to events that could had been prevented if proper patient identification had taken place.
Clinical education recorded videos scenarios with incorrect and correct processes which will be shared with at BHP staff meetings.

Risk assessment completed for BHPG, Dr. D would like to start performing additional interventional pain management procedures at his office.
The office has US capabilities, and a GE OEC 9800 Plus C-Arm Imaging Machine.
Recommendations were that cervical injections and branch blocks continue to be performed at the hospital setting as these are considered riskier procedures. Literature documents the need for readily available emergency equipment where branch blocks are performed, including airway, meds and oxygen. Office staff requirements differ from the hospital GI suite.
Joint and bursa injections and aspirations, tendons, ligaments and muscle injections, nerve blocks, and epidural steroid injections, except cervical epidural steroid injections, can be safely performed at the office setting.
Normal healthy patients and patients with mild and well controlled systemic disease would be good candidates for office procedures (ASA I, ASA II).
Patients with severe systemic disease or poorly controlled disease would be candidates for the hospital setting only.
If a patient has specific complaints, are on anticoagulants, there is a need for an ECG or cardiac clearance, procedures should be performed at the hospital.
Patients not stable or with relevant complaints might need to be rescheduled.
Patients requiring anesthesia can only be done at the hospital.

If patients require hydration, procedure should be rescheduled or performed at hospital.
No pregnant patients.
Recommendations should be reviewed by the medical director or designee.